



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

VISTA MEDICAL CENTER HOSPITAL
4301 VISTA ROAD
PASADENA TX 77504-2117

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-05-0218-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Vista Medical Center Hospital charges the above-referenced services at a fair and reasonable rate. Specifically, these rates are based upon a comparison of charges to other Carriers and the amount of reimbursement received for these same or similar services. The amount of reimbursement deemed to be fair and reasonable by Vista Medical Center Hospital is at a minimum of 70% of billed charges. This is supported by the Focus managed care contract."

Amount in Dispute: \$12,696.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It is this carrier's position Medical Dispute Resolution has no jurisdiction to proceed with dispute resolution."

Response Submitted by: Texas Mutual Insurance Co., PO Box 12029, Austin, TX 78711

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 5, 2004	Outpatient Surgery	\$12,696.50	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1, effective May 16, 2002, 27 *Texas Register* 4047, requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that

specific fee guidelines are established by the commission.”

3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
4. This request for medical fee dispute resolution was received by the Division on September 30, 2004. Pursuant to 28 Texas Administrative Code §133.307(g)(3), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on September 13, 2004 to send additional documentation relevant to the fee dispute as set forth in the rule.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - M – No MAR
 - T2 - Reduction was made on outpatient bill
 - JC – The diagnosis code submitted on the bill or reference for this treatment or service is not related to the extent of injury.
 - R – Extent of Injury
 - O – Denial after reconsideration
 - YO – Reimbursement was reduced or denied after reconsideration of treatment/service.

Findings

1. The Carrier denied services using “R – Extent of Injury” and “JC – The diagnosis code submitted on the bill or referenced for this treatment or service is not related to the extent of injury.” A Benefit Review Conference was held on June 9, 2004 and was affirmed against the claimant; on August 12, 2004 a Contested Case Hearing was held and was affirmed against the claimant. On October 27, 2004 the Appeals Panel upheld the decision of the Hearing Officers and affirmed against the claimant.

Conclusion

As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the services in dispute.

Authorized Signature

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Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.